Title 24-A: MAINE INSURANCE CODE

Chapter 34: LICENSURE OF MEDICAL UTILIZATION REVIEW ENTITIES HEADING: PL 1989, c. 556, Pt. C, §2 (new)

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§2771. REVIEW ENTITIES

1. **Licensure.** A person, partnership or corporation, other than an insurer, nonprofit service organization, health maintenance organization, preferred provider organization or employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

[1995, c. 332, Pt. M, §5 (AMD) .]

2. **Listing.** The Bureau of Insurance shall compile and maintain a current listing of persons, partnerships or corporations licensed pursuant to this section.

[1989, c. 556, Pt. C, §2 (NEW) .]

3. **Information required.** Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

A. The process by which the entity carries out its utilization review services. The information provided to the bureau must include the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State. The information provided to the bureau also must include copies of any licensure agreements the utilization review entity has in effect with any entity that sells or furnishes the utilization review entity with medical utilization review criteria and the expiration date of any such agreements. If the utilization review entity develops its own medical utilization review criteria, the utilization review entity shall include copies of any policies and procedures or both for the use of the criteria; [1995, c. 332, Pt. M, §6 (AMD).]

B. The process used by the entity for addressing beneficiary or provider complaints; [1989, c. 556, Pt. C, §2 (NEW).]

C. The types of utilization review programs offered by the entity, such as:

(1) Second opinion programs;

(2) Prehospital admission certification;

(3) Preinpatient service eligibility determination; or

(4) Concurrent hospital review to determine appropriate length of stay; and [1989, c. 556, Pt. C, §2 (NEW).]

D. The process chosen by the entity to preserve beneficiary confidentiality of medical information. [1989, c. 556, Pt. C, §2 (NEW).]

As part of its initial application, the entity shall submit copies of all materials to be used to inform beneficiaries and providers of the requirements of its utilization review plans and their rights and responsibilities under the plan.

[1995, c. 332, Pt. M, §6 (AMD) .]

4. **Transition for existing entities.** Notwithstanding subsection 1, persons, partnerships or corporations performing utilization review services on the effective date of this section shall have 90 days from its effective date to submit an application to the superintendent. The superintendent shall act upon those applications within 6 months of the date of receipt of the application, during which time the review entities may continue to perform medical utilization review services.

[1989, c. 556, Pt. C, §2 (NEW) .]

SECTION HISTORY
1989, c. 556, §C2 (NEW). 1989, c. 878, §B22 (AMD). 1991, c. 200, §A2 (AMD). 1993, c. 171, §B1 (AMD). 1993, c. 602, §4 (AMD). 1995, c. 332, §§M5,6 (AMD).

§2772. MINIMUM STANDARDS

A utilization review program of the applicant must meet the following minimum standards. [1989, c. 556, Pt. C, §2 (NEW).]

1. **Notification of adverse decisions.** Notification of an adverse decision by the utilization review agent must be provided to the insured or other party designated by the insured within a time period to be determined by the superintendent through rulemaking and must include the name of the utilization review agent who made the decision.

[1993, c. 602, §5 (AMD) .]

2. **Reconsideration of determinations.** All licensees shall maintain a procedure by which insureds, patients or providers may seek reconsideration of determinations of the licensee.

[1989, c. 556, Pt. C, §2 (NEW) .]

3. **Accessibility of representatives.** A representative of the licensee must be accessible by telephone to insureds, patients or providers and the superintendent may adopt standards of accessability by rule.

[1989, c. 556, Pt. C, §2 (NEW) .]

3-A. **Medical utilization review criteria.** The licensee must have written medical utilization review criteria to be employed in the review process. The criteria must be available for review as a part of any review conducted pursuant to section 2774, subsection 1 and a copy of the criteria must be provided to the bureau upon request.

[1995, c. 332, Pt. M, §7 (NEW) .]

4. **Information materials; confidentiality.** A copy of the materials designed to inform applicable patients of the requirements of the utilization plan and the responsibilities and rights of patients under the plan and an acknowledgment that all applicable state and federal laws to protect the confidentiality of individual medical records are followed must be filed with the bureau.

[1989, c. 556, Pt. C, §2 (NEW) .]

5. **Penalty for noncompliance with utilization review programs.** A medical utilization review program may not recommend or implement a penalty of more than $500 for failure to provide notification. This subsection does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

[1995, c. 332, Pt. M, §8 (AMD) .]

6. **Prohibited activities.** A medical utilization review entity shall ensure that an employee does not perform medical utilization review services involving a health care provider or facility in which that employee has a financial interest.

[1993, c. 2, §15 (RNU) .]

SECTION HISTORY
1989, c. 556, §C2 (NEW). RR 1993, c. 2, §15 (COR). 1993, c. 602, §§5,6 (AMD). 1993, c. 645, §B4 (AMD). 1995, c. 332, §§M7,8 (AMD).

§2773. UTILIZATION REVIEW SERVICES

As used in this chapter, unless the context indicates otherwise, "utilization review services" or "medical utilization review services" means a program or process by which a person, partnership or corporation, on behalf of an insurer, nonprofit service organization, 3rd-party administrator, health maintenance organization, preferred provider organization or employer that is a payor for or that arranges for payment of medical services, seeks to review the utilization, appropriateness or quality of medical services provided to a person whose medical services are paid for, partially or entirely, by that insurer, nonprofit service organization, 3rd-party administrator, health maintenance organization, preferred provider organization or employer. The terms include these programs or processes whether they apply prospectively or retrospectively to medical services. Utilization review services include, but are not limited to, the following: [1993, c. 602, §7 (AMD).]

1. **Second opinion programs.** Second opinion programs;

[1989, c. 556, Pt. C, §2 (NEW) .]

2. **Prehospital admission certification.** Prehospital admission certification;

[1989, c. 556, Pt. C, §2 (NEW) .]

3. **Preinpatient service eligibility certification.** Preinpatient service eligibility certification; and

[1989, c. 556, Pt. C, §2 (NEW) .]

4. **Concurrent hospital review.** Concurrent hospital review to determine appropriate length of stay.

[1989, c. 556, Pt. C, §2 (NEW) .]

SECTION HISTORY
1989, c. 556, §C2 (NEW). 1993, c. 602, §7 (AMD).

§2774. ENFORCEMENT

The following provisions govern enforcement of this chapter. [1989, c. 556, Pt. C, §2 (NEW).]

1. **Periodic reviews.** The superintendent may conduct periodic reviews of the operations of the entities licensed pursuant to this chapter to ensure that they continue to meet the minimum standards set forth in section 2772 and any applicable rules adopted by the superintendent. The superintendent may perform periodic telephone audits of licensees to determine if representatives of the licensee are reasonably accessible, as required by section 2772.

[1989, c. 556, Pt. C, §2 (NEW) .]

2. **Action against licensee.** The superintendent is authorized to take appropriate action against a licensee which fails to meet the standards of this chapter or any rules adopted by the superintendent, or who fails to respond in a timely manner to corrective actions ordered by the superintendent. The superintendent may impose a civil penalty not to exceed $1,000 for each violation, as permitted by section 12-A, or may deny, suspend or revoke the license.

[1989, c. 556, Pt. C, §2 (NEW) .]

3. **Opportunity to provide information and request hearing.** Before taking the actions authorized by this section to deny, suspend or revoke the license, the superintendent shall provide the licensee with reasonable time to supply additional information demonstrating compliance with the requirements of this chapter and the opportunity to request a hearing to be held consistent with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375.

[1989, c. 556, Pt. C, §2 (NEW) .]

4. **Authority to adopt rules.** The superintendent may adopt rules necessary to implement the provisions of this chapter.

[1989, c. 556, Pt. C, §2 (NEW) .]

5. **Rulings on appropriateness of medical judgments not authorized.** Nothing in this chapter requires or authorizes the superintendent to rule on the appropriateness of medical decisions or judgments rendered by review entities and their agents.

[1989, c. 556, Pt. C, §2 (NEW) .]

SECTION HISTORY
1989, c. 556, §C2 (NEW).